

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2009
NAME OF PROVIDER OR SUPPLIER J MONTERO RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3524 SAINT AIDEN STREET LAS VEGAS, NV 89129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of a State Licensure survey conducted in your facility on 6/24/09.</p> <p>This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>The census at the time of the survey was two.</p> <p>Two resident files and three employee files were reviewed.</p> <p>The following deficiencies were identified:</p>	H 000	<p><i>SH</i> <i>POC acceptable</i> <i>7/15/09</i> <i>by pchambers</i></p>	
H 019	<p>Director Duties-No FA/CPR</p> <p>NAC 449.15523 Director: Duties. (NRS 449.249) The director of a home shall:</p> <p>4. Ensure that a caregiver, who is capable of meeting the needs of the residents and has been trained in first aid, and cardiopulmonary resuscitation, is on the premises of the home at all times when a resident is present.</p> <p>This Regulation is not met as evidenced by: Based on record review and staff interview on 6/24/09, the director did not ensure 3 of 3</p>	H 019		<p>a) Caregivers #1, #2 and #3 had taken and completed CPR and First Aid on July 1, 2009. (Attachments TAG # H019; TAG # H019-A and TAG # H019-B respectively).</p> <p>b) Employees file should be utilized to ensure that CPR and First Aid is current and will be monitored regularly to determine if a re-certi-</p>

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

DXU911

TITLE

Director

(X6) DATE

7/15/09

If continuation sheet 1 of 8

RECEIVED

JUL 15 2009

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2009
NAME OF PROVIDER OR SUPPLIER J MONTERO RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3524 SAINT AIDEN STREET LAS VEGAS, NV 89129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 019	Continued From page 1 caregivers had received training in cardiopulmonary resuscitation (CPR) and first aid (Employee #1, #2, and #3).	H 019	con't: fication is needed. The director will monitor for compliance.	
H 032	Safety & Sanitation-Fire Extinguisher NAC 449.15525 Requirements for safety and sanitation of facility. (NRS 449.249) 2. A home must contain: (b) At least one functional, portable fire extinguisher; This Regulation is not met as evidenced by: Based on observation on 6/24/09, the facility failed to have a portable fire extinguisher with a current inspection date. The fire extinguisher was last inspected 9/28/06, and inspections are required on an annual basis.	H 032	c) 7/01/09.	
H 050	Tuberculosis-Employees NAC 441A.375 Medical facilities, facilities for the dependent and homes for individual residential care: Management of cases and suspected cases; surveillance and testing of employees; counseling and preventive treatment. 1. A case having tuberculosis or suspected case considered to have tuberculosis in a medical facility or a facility for the dependent must be managed in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 2. A medical facility, a facility for the dependent or a home for individual residential care shall maintain surveillance of employees of the facility or home for tuberculosis and tuberculosis	H 050	a) The portable fire extinguisher was inspected and was refilled on July 10, 2009. (Refer to Attachment # TAG H032). b) Fire extinguisher will be inspected regularly and will be checked by the fire inspector at least once a year to ensure that the fire extinguisher is filled and be ready for use anytime. The director will monitor for compliance. c) 7/10/09.	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

6899

DXU911

If continuation sheet 2 of 8

RECEIVED

JUL 15 2009

BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2009
NAME OF PROVIDER OR SUPPLIER J MONTERO RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3524 SAINT AIDEN STREET LAS VEGAS, NV 89129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 050	Continued From page 2 infection. The surveillance of employees must be conducted in accordance with the recommendations of the Centers for Disease Control and Prevention for preventing the transmission of tuberculosis in facilities providing health care set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. Before initial employment, a person employed in a medical facility, a facility for the dependent or a home for individual residential care shall have a: (a) Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active tuberculosis and any other communicable disease in a contagious stage; and (b) Tuberculosis screening test within the preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) vaccination. If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step tuberculosis screening test must be administered. A single annual tuberculosis screening test must be administered thereafter, unless the medical director of the facility or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 4. An employee with a documented history of a	H 050		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

6899

DXU911

RECEIVED

JUL 15 2009

BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

Continuation sheet 3 of 8

If continuation sheet 4 of 8

BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/24/2009
NAME OF PROVIDER OR SUPPLIER J MONTERO RESIDENTIAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3524 SAINT AIDEN STREET LAS VEGAS, NV 89129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H 055	<p>Continued From page 4</p> <p>NAC 441A.380 Admission of persons to certain medical facilities, facilities for the dependent or homes for individual residential care: Testing; respiratory isolation; medical treatment; counseling and preventive treatment; documentation. (NRS 441A.120)</p> <p>1. Except as otherwise provided in this section, before admitting a person to a medical facility for extended care, skilled nursing or intermediate care, the staff of the facility shall ensure that a chest radiograph of the person has been taken within 30 days preceding admission to the facility.</p> <p>2. Except as otherwise provided in this section, the staff of a facility for the dependent, a home for individual residential care or a medical facility for extended care, skilled nursing or intermediate care shall:</p> <p>(a) Before admitting a person to the facility or home, determine if the person:</p> <p>(1) Has had a cough for more than 3 weeks;</p> <p>(2) Has a cough which is productive;</p> <p>(3) Has blood in his sputum;</p> <p>(4) Has a fever which is not associated with a cold, flu or other apparent illness;</p> <p>(5) Is experiencing night sweats;</p> <p>(6) Is experiencing unexplained weight loss; or</p> <p>(7) Has been in close contact with a person who has active tuberculosis.</p> <p>(b) Within 24 hours after a person, including a person with a history of bacillus Calmette-Guerin (BCG) vaccination, is admitted to the facility or home, ensure that the person has a tuberculosis screening test, unless there is not a person qualified to administer the test in the facility or home when the patient is admitted. If there is not a person qualified to administer the test in the facility or home when the person is admitted, the staff of the facility or home shall ensure that the test is performed within 24 hours after a qualified person arrives at the facility or home or within 5</p>	H 055			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

6899

DXU911

If continuation sheet 5 of 6

RECEIVED

JUL 15 2009

BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2009
NAME OF PROVIDER OR SUPPLIER J MONTERO RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3524 SAINT AIDEN STREET LAS VEGAS, NV 89129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 055	Continued From page 5 days after the patient is admitted, whichever is sooner. (c) If the person has only completed the first step of a two-step Mantoux tuberculin skin test within the 12 months preceding admission, ensure that the person has a second two-step Mantoux tuberculin skin test or other single-step tuberculosis screening test. After a person has had an initial tuberculosis screening test, the facility or home shall ensure that the person has a single tuberculosis screening test annually thereafter, unless the medical director or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. A person with a documented history of a positive tuberculosis screening test is exempt from skin testing and routine annual chest radiographs, but the staff of the facility or home shall ensure that the person is evaluated at least annually for the presence or absence of symptoms of tuberculosis. 4. If the staff of the facility or home determines that a person has had a cough for more than 3 weeks and that he has one or more of the other symptoms described in paragraph (a) of subsection 2, the person may be admitted to the facility or home if the staff keeps the person in respiratory isolation in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200 until a health care provider determines whether the person has active tuberculosis. If the staff is not able to keep the person in respiratory isolation,	H 055		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

6899

DXU911

If continuation sheet 6 of 8

RECEIVED
JUL 15 2009

BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/24/2009
NAME OF PROVIDER OR SUPPLIER J MONTERO RESIDENTIAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3524 SAINT AIDEN STREET LAS VEGAS, NV 89129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
H 055	Continued From page 6 the staff shall not admit the person until a health care provider determines that the person does not have active tuberculosis. 5. If a test or evaluation indicates that a person has suspected or active tuberculosis, the staff of the facility or home shall not admit the person to the facility or home or, if he has already been admitted, shall not allow the person to remain in the facility or home, unless the facility or home keeps the person in respiratory isolation. The person must be kept in respiratory isolation until a health care provider determines that the person does not have active tuberculosis or certifies that, although the person has active tuberculosis, he is no longer infectious. A health care provider shall not certify that a person with active tuberculosis is not infectious unless the health care provider has obtained not less than three consecutive negative sputum AFIB smears which were collected on separate days. 6. If a test indicates that a person who has been or will be admitted to a facility or home has active tuberculosis, the staff of the facility or home shall ensure that the person is treated for the disease in accordance with the recommendations of the Centers for Disease Control and Prevention for the counseling of, and effective treatment for, a person having active tuberculosis. The recommendations are set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. 7. The staff of the facility or home shall ensure that counseling and preventive treatment are offered to each person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 8. The staff of the facility or home shall ensure	H 055			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

6899

DXU911

If continuation sheet 7 of 8

RECEIVED

JUL 15 2009

BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

6899

If continuation sheet 8 of 8

JUL 15 2009

BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA